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Promising Practices of Sexuality Counselling

The Experience in Brazil (Coletivo Feminista de Sexualidade e Saúde)

Alessandra Sampaio Chacham and Adriane Martin Hilber

Funded by WHO and implemented by the Royal Tropical Institute (KIT).

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Table of contents

Abbreviations and acronyms....8
Executive summary....9
Introduction....10
Chapter 1. Context....13
1.1 Brazil and São Paulo - Demographic and socio-economic data....13
1.2. Health care system....14
1.3 Sexual and reproductive health care....15
1.3.1 The national health system and HIV/AIDS prevention....15
1.3.2 Sexual and reproductive health in Brazil....16
1.4. Sexuality and sexual rights in Brazil....18
Chapter 2. Methodology....23
2.1 Objectives....23
2.2 Research instruments and techniques....23
2.2.1 Desk review....23
2.2.2 Priority stakeholders and key informants....24
2.2.3 Organizational diagram and standard questionnaire....24
2.2.4 Focus group discussions....24
2.2.5 Observation of sexuality-related counselling and exit and in-depth interviews....25
2.2.6 Quality assurance and data analysis....25
2.3 Limitations of the study....25
Chapter 3. The Coletivo: background and services....29
3.1 A brief history of the Coletivo....29
3.2 The Coletivo's services and clients....31
3.2.1 Clients....32
3.2.2 Counselling interventions....32
3.2.3 Coletivo staff....33
3.3 Management structure and sustainability....34
Chapter 4. Counselling – clients, content and continuity....37
4.1 A Helpline: Disque Saúde ('Dial Health')....37
4.1.1 Clients....37
4.1.2 Content....39
4.1.3 Service continuity....41
4.2 Counselling within SRH consultations (pre- and post-abortion; psychological and gynaecological consultations and pre-natal care)....42
4.2.1 Clients' characteristics....42
4.2.2 Content....44

Chapter 5. Sexuality counselling at the Coletivo – successes and challenges 51
5.1 The Coletivo's success 52
5.1.2 Efficacy and sustainability of the health service delivery setting 55
5.1.3 Has the specific sexuality counselling intervention contributed to the overall success of the programme? 57
5.2 Challenges for scaling up 58
References 61
Desk review materials 63

Abbreviations and acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretrovirals
FGD	Focus group discussion
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
KIT	Koninklijk Instituut voor de Tropen (Royal Tropical Institute of the Netherlands)
NOB	*Norma Operacional Básica* (Basic Operational Norms)
NGO	Non-governmental organization
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SUS	*Sistema Unico de Saúde* (Integrated Health System)
WHO	World Health Organization

Executive summary

This report assesses the sexuality counselling provided by the Coletivo Feminista de Sexualidade e Saúde ('Feminist Sexuality and Health Collective') in the context of their sexual and reproductive health (SRH) services. The assessment of the Coletivo is part of a larger WHO-sponsored initiative to review promising practices of sexuality counselling. Four organizations with potentially promising practices were selected following a systematic review of the literature. The Coletivo, based in São Paulo, Brazil, was selected for its historical contribution to the women's movement in Brazil in advancing sexuality counselling in sexual and reproductive health care services. This report describes the content of the counselling intervention offered and how it has been integrated into the broader SRH or HIV/AIDS programme. The study also documents the environmental, human resource and managerial context in which the counselling is provided. The study was carried out from October 2006 to May 2007. It used a variety of methodologies to assess and describe the counselling interventions using a case study approach. We hope the results of this research will contribute toward the generation of an evidence base for the development of guidelines for providing good-quality sexuality-related counselling in the provision of SRH and HIV services. The documentation of these promising practices will also contribute to the knowledge base on what is required to scale up counselling services on issues related to a healthy sexual life.

Introduction

The need to better understand how sexual and reproductive health (SRH) programmes can successfully integrate sexuality counselling into their interventions arose in 2002 when the World Health Organization (WHO) convened a strategic committee to define priorities for a new area of work on sexual health. For this meeting, WHO commissioned a review from the Royal Tropical Institute of the Netherlands (KIT) on the status of the evidence on the integration of sexual health interventions into SRH programmes, including HIV/AIDS programmes. During the strategic committee meeting, the need to develop evidence-based guidelines on how to better address sexuality within SRH programmes, particularly in counselling sessions, was highlighted. The literature shows the importance of sexuality counselling or counselling that includes discussion and information on human sexuality among other health topics. Despite the existence of many programmes that purported to include such issues, few programmes have been documented. It was found that in many of the intervention areas prioritized by the strategic committee, the situation was the same: there was too little evidence to form the basis of future service delivery guidelines in specific sexual health services. As a result, the new area of work set out to build the evidence base for programming in sexuality and sexual health by documenting promising programmes that successfully included key sexual health interventions.

Based on the results of the reviews, criteria were established to select programmes to be assessed, as a first step towards building the knowledge base for future guidelines. The criteria were based on the hypothesis that talking about sexuality is possible in diverse cultural, population and geographical contexts and that implementation of sexuality counselling interventions in SRH or HIV programmes improves the general well-being and sexual health of the target group. The programmes selected to be assessed were identified through a systematic literature review and review of the grey literature. Once identified, potential programmes were contacted to ensure interest in the assessment, to confirm that the programme still included the sexuality counselling component in their services and that the programme continued to be successful from the programme manager's perspective. Local and international supporters and donors to the programme were contacted to determine the current status of the programme and the counselling interventions to confirm reports from programme managers.

Programmes selected, therefore, met the following criteria:

1. Counselling is currently being run, as an intervention or part of an intervention.
2. Evidence exists (programme evaluation reports) for the quality of the sexuality counselling interventions.
3. The intervention has been in place for more than the last three years.
4. Counselling on sexuality-related issues is comprehensive.
5. Service types and target groups, with a preference for cultural and programme diversity.

KIT and WHO selected four programmes where the assessments were to be conducted on SRH or Human Immunodeficiency Virus (HIV) programmes that had been previously assessed to be broadly successful, either by external assessment (most desirable) or internally by a donor or partner. This report presents the results of the descriptive study done with the Coletivo Feminista de Sexualidade e Saúde (Coletivo), one of the four programmes selected which is currently proving counselling that specifically addresses sexuality-related issues within the context of its services.

The Coletivo, located in São Paulo, Brazil, was founded in 1981 to promote and provide integrated health and sexuality-related services for women. Working from a feminist perspective, the Coletivo is one of the leading women's health activist organizations in Brazil that provides direct ambulatory SRH services, specific mental health services (private individual and couples counselling), workshops for diverse populations (male and female sex workers, gay and lesbian health, young people, older women, rural workers etc.) and training and capacity building for other organizations aiming to work on sexuality specifically within their own service setting. For all of its services, it has developed training materials and other tools to facilitate individual and community knowledge of the issues. One the main characteristics of these services is that they have always incorporated sexuality and sexual health counselling as a standard component of all interventions it offers, even before the onset of the HIV/AIDS epidemic when sexual health and sexuality-related issues became urgent health care needs.

This report describes the content of the counselling intervention offered and how it has been integrated into the Coletivo's broader SRH or HIV/AIDS services. The study also documents the environmental, human resource and managerial context in which the counselling is provided. The study was carried out between October 2006 and May 2007. It employs a variety of methodologies to assess and then describe the counselling interventions using a case study approach. We hope the results of this research will contribute toward the generation of an evidence base for the development of guidelines for providing good-quality sexuality-related counselling in the provision of SRH and HIV services. The documentation of these promising practices will also contribute to the knowledge base as to what is required for scaling up counselling services on issues related to a healthy sexual life.

Chapter 1. Context

1.1 Brazil and São Paulo – Demographic and socio-economic data

Brazil is a large country with an estimated population of 187 million inhabitants in 2007. It also has one of the top 15 world economies, yet it remains at only the midpoint on the Human Development Index. Inequality is at the heart of this contradiction. Brazil is one of most unequal countries in the world: in 2002 the richest 10% of the population controlled 48% of the Gross Domestic Product (GDP), while the poorest 10% had a participation of 0.7%. There is inequality between north and south, between men and women, between black and white. If the same development criteria that place Brazil at number 74 in the league table of nations were to be separately applied to the white and black populations, the white population would come in at 49, with the black population 59 places lower in 108th place (RFS, 2003).

Although the Constitution states that men and women are equal under the law, gender inequalities are pervasive and clearly expressed in the economic gap between men and women. While the GDP per capita for men reaches US$ 10,416, women make less than half of that, with only US$ 4391 (UNDP, 2003). Although better educated than men, and now comprising 46% of the work force, women earn less than half than men. Even in metropolitan areas where there is less disparity, women make two-thirds of what men make. Women are also often confined to lower-paid jobs in the service sector (71% of working women are in the service sector, 19% in agriculture and only 10% in industry). Unemployment also hits women harder, especially young and less educated women. In 2002, the unemployment rate was 22% for women between 15 and 24 years old, while it was only 11% for men of the same age group. Another powerful indicator of the subordinate position of women in Brazilian society is the low number of women who occupy seats in the Parliament: women won only 9% of seats in the 2000 election (UNDP, 2003). The high prevalence of domestic violence is another symptom of gender inequality: a national survey from 2001 found that 33% of the women interviewed reported they had suffered physical violence from men at least once in their lives (Saffioti, 2004).

Regional inequalities are also significant. The south of Brazil and, in particular, the southwest region are much more developed than the north and northeast states. São Paulo, in the southwest region, is the largest and wealthiest state in the nation with over 42 million inhabitants in 2007. In 2004, according to a national survey (PNAD), the number of people living below the poverty line was less than half in Sao Paulo compared to the country as a whole: 11.7% poor and 2.6% indigents compared to 26.6% and 5.6% (IBGE, 2005) respectively nationally. Its capital, São Paulo city, is also the largest and wealthiest city in the country, with a population of 11 million people and over 18 million in its metropolitan area (CENSO, 2000). A great industrial and finan-

cial centre, São Paulo has been attracting migrants in search of better living conditions for over a century, first from Europe (mainly from Italy and Portugal), then Japan, and, since the 1960s, from the northeast of Brazil, the poorest region of the country. The city is now a huge urban sprawl surrounded by slums and very poor areas sometimes located close to expensive suburbs and exclusive neighbourhoods. It is a very diverse city, with people from different ethnic and cultural backgrounds. Since its beginnings, the Coletivo has strived to attend to São Paulo's diverse populations with its services.

1.2. Health care system

Between 1964 and 1985, Brazil was under military rule. Economic growth rates were high, but social inequality deepened. In the late 1970s, Brazil started a long and tumultuous democratization process, accompanied by economic crises and rampant inflation. During this time, the responsibility for public health care was fragmented, excessively centred on hospitals, focused on curative rather than preventative services, and heavily dependent on contracted private service providers, particularly in the case of hospital care.

The 1980s were primarily a period of democratization and greater political participation processes that were also reflected in the changing health policies and national initiatives in reproductive health. A very strong demand for reform of the entire health system, spearheaded by professional and academic circles and social reform movements, led to the passage of the 1988 constitutional provisions that established universal health care through the Integrated Health System (*Sistema Único de Saúde* – SUS).

The new Constitution adopted in 1988 was one of the critical breakthroughs of the decade, as it established principles of gender and social equality in all domains. The Constitution represented a victory for the 'health reform movement' – which had been active since the 1970s. It defined health as a human right and set forth the SUS as a universal, integral and decentralized system with built-in public accountability through health councils at national, state and local levels.

Today, the SUS provides over 70% of out-patient and hospital care, managing a vast network of public and accredited private services. For approximately 120 million Brazilians, SUS is the sole source of medical care. In 1994, primary care strategies were included in SUS national guidelines to correct the hospital-centred bias (Mansur, 2001). In 1996, a new operational norm to guide SUS implementation was approved (*Norma Operacional Básica* (NOB) 01/96). This regulation, which grants local managers autonomy to define priorities and allocate resources, constitutes one of the crucial elements in the advancement of reproductive health policies, with respect to both access and quality of services. The same year a new source of health financing was created that temporarily solved the persistent SUS funding problems: the Temporary Fee on Financial Trans-

actions (0.20% on bank transactions). Although temporary, this tax persists until today, but most of the resources raised by it have not been designated to health care services. Since private plan users who are covered by insurance also have access to services provided by SUS, in 1998, a new regulatory framework instituted rules for reimbursing SUS for their care, but this law has also to be fully applied and regulated (Mansur, 2001). Lack of resources for health care persists as a consistent problem today.

1.3 Sexual and reproductive health care

1.3.1 The national health system and HIV/AIDS prevention

The Brazilian government's public health response to the AIDS epidemic has been characterized by multiple initiatives to fight the epidemic. These integrate prevention and treatment and aim to address the needs of those most vulnerable to infection, among them sex workers. Brazil's public policy on HIV is based on the promotion of rights and of a leading role for civil society as a strategy of health promotion – an approach that has also been promoted by the feminist movement in Brazil since its beginnings, as part of the concept of *saúde integral* (comprehensive health).

In spite of the numerous challenges and problems that remain, the Brazilian response to AIDS is considered exemplary internationally. Mortality has been reduced to half of what was projected in 1990, the epidemic is stabilized, the rate of new infections has been declining since 2000, and free antiretrovirals (ARVs) are available to all those who need them. The World Bank's projection, that in 2000 Brazil would have 1.2 million people infected, did not come to pass: in fact there have been an estimated 600,000 people infected with HIV, or 0.5% of the population. A Ministry of Health study found that from 1996 to 2006, among 15−24-year-olds, condom use at last sex had jumped from 6.5% to 57.3%. A recent study in Brazilian state capitals reported that 69.8% of girls and 68.2% of boys used contraceptive protection at first intercourse, and, among them, 80.7% of the girls and 88.6% of the boys said they used condoms (Ministério da Saúde, 2005a).

One of the most distinguished characteristics of this programme is the long-standing partnership between governmental agencies and non-governmental organizations (NGOs) to combat the spread of HIV/AIDS. This partnership is a good example of how non-governmental programmes can help the State to create innovating approaches in their policies and programmes, focusing on the needs of specific sectors of the population, such as female sex workers or poor married women. In Brazil, it was the NGOs that initially drew attention to HIV by contributing to the production of knowledge and information on its different therapeutic, preventive and so-

cial implications. They contributed by developing multiple actions to raise awareness and offer treatment to their target populations – actions frequently financed by the Ministry of Health, as only the government has the resources necessary to finance the large public health campaigns and guarantee access to treatment for the general public.

In the case of sex workers, the National Programme of Sexually Transmitted Infections (STIs) and AIDS, since its inception, established a partnership with sex workers' organizations, such as Davida and the National Network of Prostitutes (Davida, 2007). This partnership developed a guidance document called *Directives, Principles and Strategies to Prevent STIs and AIDS among Sex Workers*, including women, men and transvestite sex workers. The document has a human rights framework and recommends a leading role for sex workers in the design, implementation and evaluation of public policies, and the promotion of non-discriminatory access to the national health system and educational initiatives targeted at clients and partners of sex workers. The Ministry of Health also supports several sex workers' organizations in their prevention efforts and sponsored a seminar on AIDS and prostitution in 2002. One of the results of this long-term partnership is the campaign '*Sem Vergonha Garota: Você Tem uma Profissão'* ('No Shame, Girl: You Got a Profession') to promote awareness of the rights of sex workers as citizens, along with promotion of health, self-esteem and skills for condom negotiation with clients (Ministério da Saúde, 2002).

In 1997, the women's health movement's reproductive health initiatives began collaboration with the National AIDS Coordination. As a result, condom distribution doubled, as did treatment rates of STIs among women. In light of the rapid expansion of HIV among women, prevention and treatment of HIV among poor women was defined as a priority for the next phase of the National HIV/AIDS Programme. During the 1980s the rate of infection was 6.5 times higher among men than women. In the 1990s this ratio fell to 2.4 men for each woman. Ministry of Health statistics show that more than half of all AIDS cases occur among 20 to 34-year-olds, suggesting that infection took place at a younger age, often during adolescence. In 2002 the bulletin from the National HIV/AIDS Programme showed that among young people aged 13–24 years the rates of infection are already the same between males and females. In this most undesirable of ways, young women have achieved equality with men (Ministério da Saúde, 2005b).

1.3.2 Sexual and reproductive health in Brazil

Obstetric care, maternal mortality and illegal abortions

Maternal mortality is still high and linked to a number of factors in Brazil. The most recent estimates for maternal mortality rates range from 76 in 2004 (data from Ministry of Health) to 260 per 100,000 births in 2000 (data from WHO) (Diniz, Chacham, 2004). Since roughly 95%

of deliveries take place in hospitals, high rates are explained by lack of antenatal care, poor assistance in delivery, and unsafe abortions. In a country where abortions are only legal after rape or to save the life of the mother, and where even legal abortions are hard to obtain, there are many unwanted pregnancies and somewhere between 700,000 to one million unsafe and illegal abortions annually. Some poor women go to unskilled abortionists, putting themselves at high risk of hemorrhage and infection; others use the drug Cytotec (Alves, 1996) purchased over the counter at local pharmacies. Many women arrive at hospital looking for help after a clandestine procedure. Nationally, abortion is the fourth most common cause of maternal mortality and the first in many metropolitan areas (Alves, 2007).

More recently, in relation to obstetric care, there has been investment in hospital equipment and training of health professionals, especially nurses, and an award has been created to give higher visibility to services that provide good-quality care in childbirth. The focus on obstetric assistance has contributed to a reduction in hospital-based maternal mortality, and the number of states that set up committees to investigate maternal deaths has increased from seven to 12. However, despite the widespread access to hospital deliveries and improvement in obstetric care, maternal mortality still persists as a challenge to the national health system. The very high Caesarean rate (around 42% in 2004) also contributes to the high rate (SINASC, 2004).

Access to contraceptives and sterilization

Until 1985, when the public health system began to offer contraception, women depended basically on the market and the non-governmental family planning system to supply contraceptives, primarily the pill. The quality of services provided by the non-governmental sector was also very problematic. The lack of adequate screening and information resulted in contraceptive failures, adverse side effects and access problems, and reversible methods became increasingly discredited among women. Since abortion was illegal and risky, the demand for surgical sterilization increased.

Sterilization began being widely offered by private hospitals, by contract service providers, and by individual physicians in public hospitals. To justify its increased frequency, doctors often performed the procedure during Caesarean operations. By the early 1980s, this trend had already become apparent, and the Ministry of Health set a priority to reduce the number of sterilizations. But ten years later the programme's impact in this area had been minimal. Although contraceptive use among married women grew from 66% to 77% between 1986 and 1996, the use of the pill declined from 29% to 21%, but sterilization increased from 31% to 40% (DHS, 1996).

Tubal ligation is the most widely used contraceptive method offered by the SUS system. In preparation for Cairo, Elza Berquó, a prominent demographer who has been studying reproductive health since the 1970s coined the expression "the culture of sterilization" to describe the

widespread use of sterilization, which in Brazil involves women of different generations and races as well as physicians, and permeates both the private and public health systems (Berquó, 1994).

Recent progress in women's health

The national coordination body of the Women's Health Programme has concluded an assessment of policies implemented from 1998 to 2002. The assessment identified a number of areas where clear progress had been made. Among those is that the coverage of cervical cancer prevention screening has expanded, reaching out to women who have never before had a Pap smear test. Also, a national programme was established to provide early detection and treatment of sickle-cell disease, which mostly affects the black population.

Advances have also been evident in relation to services that provide care to women victimized by sexual and other forms of gender-based violence. A first important step was the approval, in 1998, of a SUS protocol (*Norma Técnica de Atenção às Mulheres Vítimas de Violência*) that provides guidelines for these services, including those related to emergency contraception and abortion procedures in the case of rape, life risks and HIV prevention. Another protocol adopted in 2002 obliges all cases of gender-based violence seen by the public health system to be recorded. A large number of health professionals have been trained and presently there are now 245 gender violence services (82 hospitals and 163 clinics) that offer counselling and treatment, including emergency contraception and HIV prophylactic treatment. Of these, 73 services provide abortion procedures in the two cases permitted by law (Ministério da Saúde, 2005c).

It must be said, however, that the priority given to SRH at the federal level does not always translate into efficiency and quality of care across the system. SUS is a gigantic machinery delivering services to 100 million people across an extremely diverse country. Decentralization has helped to reduce the gaps between managers, providers and users and has favored transparency and accountability. But tensions also remain with respect to power relations at the various levels of the system, particularly regarding allocation rules and their effects on the flexibility allowed to municipal managers. Given the extreme variation in technical capabilities, human resources and ideologies at decentralized levels, federal rules and incentives do not always ensure access to or quality of services. Consequently, assessments made of progress and gaps may vary widely, depending on from where one assesses the policy performance.

1.4. Sexuality and sexual rights in Brazil

It has been said that Brazilians have a very ambiguous approach to sex. On the one hand, they confer great importance to sex and sensuality as a part of the image they have about themselves

as people. If in Europe and the USA sex is seen as an eminently private phenomenon, in Brazil it is taken as part of the peculiar 'nature' of Brazilian reality. Here, sensuality is celebrated and is related to what it means to be a Brazilian: a sensual, hot people – an image that Brazilians perpetuate not only to themselves but to the rest of the world (Parker, 1991). In contrast, Brazil has historically been influenced by the Catholic Church, and the prevalence of patriarchal families and unequal gender hierarchies are testimony to this legacy.

During the colonial times of the 19th century, all the power emanated from the 'patriarch', the land owner with power of life and death over those under his 'protection', where family was equated with the large 'official' extended family plus the concubines and illegitimate children in the background. This model generated a dual moral standard for men and women, resulting in an extreme differentiation between sexes, where men are superior, strong, virile and active, and women are inferior, weak, desirable and subjected to male domination. This model gave men liberty to pursue physical pleasure while limiting women to the classical Madonna/whore dichotomy: either they were 'honest' wives serving their husband in bed or 'loose' women engaging in non-marital, non-procreative sex. As a consequence, sex for pleasure, sexual promiscuity, prostitution and homosexuality have historically been objects of stigma and repression in Brazilian culture, seen by the Church as sin and by medicine as sickness. The modernization of sexual mores since the 1960s was not enough to erase the impact of those values (Parker, 1991).

A mixture of progressive discourse and traditional models marks the exercise of sexuality by contemporary Brazilian women. At the same time they feel the need to affirm publicly their satisfaction with their sexual lives (after all, "all Brazilian women are hot") and deny any problems related to pleasure and or orgasms. The Brazilian woman presents herself as conservative in relation to the more controversial and still stigmatized aspects of her sexuality such as sexual orientation, number of sexual partners and extra-marital sex (Chacham, Maia, 2003). While social changes in recent decades legitimized (and made almost mandatory) women's search for sexual pleasure, the persistence of traditional values kept pleasure inscribed within stable, romantic heterosexual partnerships.

The same ambiguity that characterizes sexual practices and discourse in Brazil appears in its legal codes. Historically, sexual behaviour has been less legally regulated than countries with Anglo-Saxon influence. Since the Proclamation of Republic in 1889, Church and State were officially separated, and behaviour such as homosexuality and sodomy were not forbidden. Even prostitution is not illegal in Brazil, albeit it has a very ambiguous legal status: to work as a sex worker is not illegal, but it is not legal either. Prostitution is not a criminal act under the Brazilian criminal code, but the attitude towards sex workers is often condemnatory, moralistic and punitive. No one is arrested for prostitution, but sex workers are under constant threat of arrest for vagrancy or obscene behaviour. The same has happened to homosexuals, who have suffered persecution and threats under laws against obscene behaviour.

In contrast, the Brazilian civil code has always been a very strong in protecting 'traditional family values'. Women's behaviour, especially sexual behaviour, was heavily regulated. Until 1962, a married woman was not free to work and hold a contract without authorization by her husband. Men were legally the head of the household. Only in the late 1970s did divorce become legal in Brazil, although with a series of limitations. 'Illegitimate' children's rights where also equalized to those of children born to married couples. These antiquated codes persisted; for example, until the new civil code (in 2002), a man could void a marriage if the woman was not a virgin, and an unmarried daughter who was 'dishonest' (not a virgin) could be disinherited. Adultery was also a crime under the penal code, although the law was rarely enforced and juries frequently acquitted men who killed unfaithful partners. Today, the law guarantees equality between men and women in all aspects of life. The family law protects different kinds of families, and even homosexual partnerships are slowly being recognized by courts of law. Nevertheless, the strong influence of patriarchal and Catholic traditions has a clear impact on Brazilian sexual practices today. The lack of access to sexual education is still a problem many adolescents and adults face in developing a good and healthy sexual life.

Chapter 2. Methodology

2.1 Objectives

The general objectives of the study were to define the content of sexuality counselling and assess factors influencing the quality of counselling that may contribute to improved sexual health in four different SRH programmes that were considered to have successful experiences in offering sexuality counselling among their services.

The specific objectives were:

1. to contextualize counselling services within a broader service delivery environment;
2. to document the content of the counselling related to sexuality issues;
3. to assess the quality of the counselling related to sexuality issues;
4. to assess the way the health system and environmental factors influence the content and quality of counselling; and
5. to assess, as far as possible, the contribution of the counselling intervention to the success of the broader SRH programme.

In order to meet the objectives, we took a case study approach using qualitative techniques to focus on understanding the content and context of the sexuality counselling offered. We also sought to identify factors influencing the quality of counselling and the relative contribution of the counselling intervention on broader programme goals and objectives. In order to enable comparison and contrast of the findings between various sites, standardized instruments were adapted to the local context. From December 2006 until June 2007 the programme was assessed using the adapted rapid assessment methodology. Ethical permission for the study was obtained from both the WHO Ethical Review Board and the Brazilian National Ethical Committee.

2.2 Research instruments and techniques

2.2.1 Desk review

The desk review included an analysis and synthesis of institutional reports, evaluation of counselling service reports, policy reports at both national and district level, training materials, and health service statistics (ratio of clients to providers, health information resources, partner involvement notification, teaching aids). Baseline data and information on the profile of the clientele were collected using the records available. This information allowed us to contextualize the counselling

intervention within the broader programme. In addition, information on the cultural and religious context were gathered and summarized from the reports to further assist in interpretation of the assessment results.

2.2.2 Priority stakeholders and key informants

At the beginning of the assessment, interviews were conducted with priority stakeholders to identify the relevant key informants. The following types of stakeholders/key informants were interviewed:

- District health coordinators
- Project managers and directors
- Coletivo staff
- NGO representatives involved in providing SRH education, advocacy and services (referral organizations)
- Community representatives familiar with the services
- Users or clients of the services.

2.2.3 Organizational diagram and standard questionnaire

A mapping of the institutional setting was carried out with managers of the programme to help understand the institutional setting and the possibilities for scaling up its projects. A standard structured questionnaire was used for interviewing the management and staff of each selected project; this assisted the study team to document commonalities and differences in the interventions under study.

2.2.4 Focus group discussions

Focus group discussions (FDGs) were conducted in order to map out the normative context, assess community perceptions of counselling services provided, and identify sexuality counselling needs and accessibility to counselling and other relevant services. Four FGDs were conducted with the primary target populations of the services. The participants were selected according to age and social class. Questions related to their understanding and opinions of the counselling practices they received with respect to sexuality. For the first focus group we recruited older (40 to 65-year-old) low-income women, for the second one, younger (20 to 35-year-old) low-income women, and for the next two groups, younger and older middle-class women. Each FGD involved between six and 12 people and lasted approximately one and a half hours. We did not hold a FGD with the manag-

ers of the projects and others responsible for the counselling services, given their small numbers (seven at the time), but an in-depth interview with each.

2.2.5 Observation of sexuality-related counselling and exit and in-depth interviews

Direct observation of consultations and exit and in-depth interviews was conducted to assess the quality and appropriateness of the content of the counselling session from the perspective of the clients and counsellors. Eight direct observations of consultations and 28 exit interviews were carried out. We conducted ten in-depth interviews with clients of different types of service offered by the Coletivo. For the Coletivo's telephone hotline, institutional records and data on the hotline callers' profiles, needs and referrals were analysed.

2.2.6 Quality assurance and data analysis

Validity of the data was assured by triangulation. Data were triangulated by interviewing different stakeholders, key informants and client groups: the same questions were asked to the different study groups, as well as in individual and group discussions. The results from interviews, observations and desk review were compared and contrasted in a systematic way, and results were validated from the questionnaires using the same process. Analysis of the quality of counselling interventions was assessed against a standardized quality assessment framework for counselling interventions. The open-ended questions were coded, and organized in relevant categories based on the conceptual framework. FGD outcomes were coded according to the questions included in the topic guide and categorized. A matrix was developed to triangulate results.

The standard questionnaires were entered into the computer for analysis using the SPSS statistical software programme. The outcomes were reviewed as observation tables, which can be compared for each intervention as well as between the different research sites. A uniform coding system was used in all selected research sites. Comparison of results and final analysis of findings were conducted by the country research team. Results were shared with programme directors at the conclusion of the assessment process.

2.3 Limitations of the study

The main limitation of this study was the organization's small caseload. Unfortunately, the Coletivo has a very small clientele today – around 40 to 50 women were attended to per month during the study period. One of its main counsellors may see three to five women on average per week,

and the doctor would see around ten, in general, for pre-natal care. The small client load did not allow us to sufficiently assess the quality of the counselling services currently, as too few clients were seen during the assessment period. As a result, we had to use documented reports to analyse institutional outcomes rather than patient reports and results to evaluate the services. Although we did get some reports on individual outcomes (documented through patient records and self-reported in exit interviews), there were too few to base our analysis on these results, however interesting they were. As it is a small but extremely innovative institution, we did seek not to evaluate the Coletivo as a health clinic exclusively, but rather for its role as an NGO that made a profound impact on women's health care in Brazil.

Chapter 3. The Coletivo: background and services

3.1 A brief history of the Coletivo

The Coletivo was founded in 1981. Since its inception, it has steadily become a reference point for the promotion of and research into women's health and sexuality both in Brazil and Latin America. It was founded by a group of women, some medical doctors, who were politically active within Brazil (movements against the dictatorship) and also influenced by the activism of European feminists. In its first formation the group was called 'Sexuality and Politics' and sold a magazine called *'Revolutionary Pleasure'* between 1981 and 1982. In 1984, they changed their name to the Coletivo Feminista de Sexualidade e Saúde and started to offer health care to women following the principles of 'sweet medicine'. This alternative promoted a less invasive and non-medicalized approach to health care that was developed under the influence of the Dispensaire des femmes, a Swiss feminist health clinic in Geneva, where one of the Coletivo's founders spent some time in training. After training themselves and promoting several workshops to train lay women who were part of the women's health movement, they finally opened a clinic in 1984 in their old building with donated materials and support from the Dispensaire and other European NGOs. The clinic worked out of its original building until 1993 when, with help from the US-based International Women's Health Coalition, they were able to buy the house where their office is currently located – a very important contribution for a NGO, and one that has allowed them to maintain a continuity of services.

Since 1984, the Coletivo has maintained a clinic that attends to women of all ages and origins, charging according to a sliding scale. Inspired by the international feminist experience, the method utilized in the clinic is critical of the classical medical approach. Instead, it sought a 'soft' model, using natural treatments and herbs whenever possible, and less aggressive forms of treatment. This model also emphasizes women's own knowledge of their bodies as a central element of women's health. Women are seen as a person, the subject of action, able to understand, decide and take care of their own bodies and lives. Today the Coletivo is an NGO that offers basic health care to women with a humanistic and feminist approach. Its services are based on a holistic view of women's health where the woman is warmly received and understood in her totality. The Coletivo seeks in its interventions to stimulate the active participation of women in their diagnoses, treatment and care.

3.1.1. The Coletivo's contribution to the women's movement in Brazil

The Coletivo's contribution to the improvement of women's health is not restricted only to its direct intervention with its target population. The Coletivo also actively participates in discus-

sions on public policies in different ways. It presents an alternative humanistic model of health care that is replicable and that demonstrates that with political will, well-trained personnel and scarce resources it is nonetheless possible to reverse the mistreatment and misinformation on SRH care to which women in Brazil have been historically subjected. It is also a politically active institution and historically one of the first feminist institutions in the country and region. For example, the Rede Feminista de Saúde, the Brazilian National Feminist Network on Reproductive and Sexual Health and Rights had its offices in the Coletivo for almost seven years. Several former Coletivo members and founders went on to occupy important positions in the Ministry of Health and in the local and state health departments, as well as in universities and research institutes. Their experience in the Coletivo was a fundamental part of their lives, as their actions and discourse now demonstrate.

One of the most remarkable examples of the Coletivo's activism and influence is one of founders, Dr Maria José Araújo, who went on to become the first Director of the municipal women's health department in São Paulo and later the Coordinator of the Ministry of Health's Division on Women's Health. Another founder of the Coletivo, Dr Simone Diniz, a professor at the University of São Paulo and a founder of REHUNA (Network for the Humanization of Birth) is also another example of the great influence the Coletivo has had in spreading the ideals of humanization and a rights-based approach to health care in the public sphere.

The Coletivo's political role and contribution to developing an alternative model of health care is acknowledged by several international organizations such as the International Women's Health Coalition, one of their main supporters since its early years. Another organization, the Population Council, dedicated an entire issue of its series *Quality/Calidad/Qualité* to Coletivo in 1996, describing its history, philosophy and services. The Population Council, in this publication, presented the Coletivo as pioneers in offering alternative services to women's health care. It concluded: "Coletivo has never deviated from its original objectives and its Institution has kept relatively stable. They have been able to continuously evolve by keeping open and flexible to new ideas and different perspectives. Instead of staying still, they always sought new allies and new ways in the effort to arrive closer to their ambitious objectives."

3.2 The Coletivo's services and clients

Services provided by the Coletivo include:

- a helpline called Disque Saúde ('Dial Health'), a free and anonymous service where women and men can call to get their questions on sexuality, sexual health and rights answered; it used to be called SOS Mulher ('SOS Women'), but the name was changed to become a more inclusive service, and it is the only service in the Coletivo also provided to men;
- gynaecological consultations and pre-natal care;
- pre- and post-abortion counselling;
- psychological consultations (several clients are women in situations of violence who were referred by the Coletivo hotline);
- support, referral and information in situations of domestic, sexual and racial violence;
- a library open to the public with books, videos and educational material in the area of women's health;
- partnerships with government offices (at municipal, state and federal levels) and NGOs to develop projects, training programmes, seminars and workshops in the area of women's health;
- partnerships with universities and other institutions to develop research in the area of women's health;
- promotion of workshops, seminars, training programmes and courses on health, gender and sexuality-related issues; and
- production of articles, manuals and books on health, gender and sexuality issues.

At the time of this assessment, the Coletivo was open Monday through Friday from 9am in the morning to 5pm in the evening. The following services were offered:

- The counsellor/trained health provider offered consultations three times a week, on Tuesdays, Wednesdays and Thursdays. She offered gynaecological consultations and pre- and post-abortion counselling. Sexuality counselling is typically done during one to those consultations. She attended to an average of three to five women a week.
- The gynaecologist offered pre-natal care and gynaecological consultations once a week, all day on Thursdays. She attended to an average of ten women per day.
- The psychologist attended to three to five clients per week, on Wednesday and Thursday afternoons.
- The hotline attendant receives phone calls during the day, every day from 9am to 5pm. During lunchtime an answering machine takes messages that she can return later. Over the past two years, people have also been able to send their questions by email (available on its website), and the attendant answers them.

3.2.1 Clients

Over 6,000 women have been attended to at the clinic since it opened its doors as a clinic. In 2005 and 2006, the Coletivo attended to almost 700 women and had around 200 new clients for the following services:

- 118 clients for gynaecological consultations;
- 48 clients for pre-natal care;
- 48 clients for pre-abortion counselling; and
- 10 for mental health services (consultations with psychologists for therapy).

More information about the Coletivo's clientele is presented in section 4.2.1 of Chapter 4.

3.2.2 Counselling interventions

Several types of counselling interventions are available. They are:

- A helpline called Disque Saúde ('Dial Health') – a free, anonymous service that women and men can call to get answers to their questions on sexuality, sexual health and rights. People can also send emails with their questions on SRH.
- Pre- and post-abortion counselling – during these consultations they explore women's feelings about their pregnancy, the procedure, and provide referrals if needed. This service is provided to women, although it is common that the couple participates in this consultation together.
- Psychological consultations (several clients are women in situations of violence, who were referred by their hotline) are offered to women only.
- Gynaecological consultations and pre-natal care are provided to women both by a trained health aid and a gynaecologist. Most of the sexuality counselling happens during these consultations.

A philosophical mandate to providing sexuality counselling

Although the Coletivo does not have a specific service offering sexuality counselling per se, counselling which incorporates a discussion about the client's sexuality may occur within any of the services described above, including the gynaecological consultations and pre-natal care. To understand the way it occurs is fundamental to understanding how successful the Coletivo is in incorporating sexuality counselling in its varied services.

First and perhaps most fundamental, discussion about a woman's sexuality is a primary component of the Coletivo's SRH services. Since its inception, sexuality was fundamental to the Coletivo's holistic approach to women's health. The basis (and success) of this foundation

was evident in the approach taken. In the initial consultation, the woman (the first-time client) is asked to fill out an extensive questionnaire with questions on almost every aspect of her life, not only on her medical and reproductive history. There are several questions about her sexual life, such as how often she has sex, if she is satisfied with her sexual life, or if she has any problems or complaints with this aspect of her life. This life history is then used to guide discussion around the sexual or reproductive health care services she has come for. Sexuality is thus made a fundamental part of women's life and health history, and all care and treatment departs from this basic supposition. With this approach, women, regardless of personal or social position, are given space repeatedly throughout their consultations to address sexual health problems or concerns as they may arise or affect the particular reason for being seen at the clinic. For women who are culturally or socially restrained or embarrassed to raise these issues, the repeated and straightforward – even routine – approach, creates a safe and unencumbered space to raise issues related to sexuality that these women would perhaps not feel comfortable to raise in other circumstances.

The most evident result of the accumulated body of knowledge and experience of this humanistic approach to women's health care is the project '*Fique Amiga Dela*' ('Get Friendly with Her') that consists of a booklet and a workshop to teach women to get to know their genitals and reproductive system and to have a pleasurable and healthy sexual life. The material is available on a website of the same name that receives over a thousand hits every month. The Coletivo's reputation for clear sexuality information is evidenced by the number of emails it receives with questions about sexuality and SRH that its attendant answers. It also spreads its philosophy through workshops and speeches. The effort to keep this philosophy alive in practice after 20 years of attending to women is clear in the way people are hired, and how they are supported and trained to maintain this approach – as we will address in the next chapter.

3.2.3 Coletivo staff

The Coletivo's services are provided by a small staff. During the months we performed our assessment its staff was made up of six women:

- one secretary who was also responsible for helping with the management of projects;
- one financial/administrative aide who was also responsible for assisting with the hotline when the main person responsible was away;
- one hotline attendant who was also responsible for managing some of their projects and writing new ones; she also offered workshops on gender and sexuality-related issues;

- one counsellor, a trained health agent who attends to women, offering gynaecological examinations and pre-abortion counselling; she also helps with different projects;
- one psychologist who offered therapy sessions at low cost for women and also helps to manage some of the projects; and
- one gynaecologist who provides the gynaecological consultations and prenatal care.

Aside from the permanent staff, one of the founders, Dr Simone Diniz, continues to play an active role as a research coordinator. Dr Diniz also participates in the Coletivo's weekly staff meetings. Her primary role is in overseeing the philosophical mandate of the organization by ensuring that the 'vision' or grounding principles that have guided the institution since its inception are not lost in the staff's daily struggle to provide quality services in a sometimes precarious financial setting.

3.3 Management structure and sustainability

The institution is managed in a truly collective way. Every three months two people are in charge of management. One supporter (a member of the advisors) acts as the legal representative, so they do not need to change their paperwork every three months.

The organization's horizontal structure is consistent with Brazil's early NGOs and unions that, in response to a history of dictatorship, sought a political structure that was fundamentally democratic and socialist in nature. While this democratic management structure has successfully allowed for skilled and unskilled staff to partake equally in handling the day-to-day management tasks of the organization, leadership challenges persist, particularly when funding and/or existential crises were faced – as will be discussed in subsequent chapters.

The current financial status of the Coletivo is precarious. It is facing a dilemma right now. It is a historic NGO (for Brazilian standards), as one of the oldest feminist organizations still operating. As a result, many international institutions that traditionally supported them assume they are self-sufficient and thus are not seen as a priority as agencies shift to supporting newer organizations, particularly those that specialize in addressing the needs of young women and minorities. Organizations such as the Coletivo that had early financial support from foreign donors have either folded or sufficiently diversified their funding portfolio to allow them to be self-financing. Those NGOs that have been the most successful, however, are research- rather than service-based organizations. Services require fees rather than grants, and in a country like Brazil, where universal health care is available, fees paid for services – albeit unique services which many women feel they cannot get from the public health services – are nonetheless a

luxury. As a result, the challenge remains that regardless of how innovative the Coletivo's approach is, in Brazil, where private insurances must cover such amenities, these unique services cannot compete with the private care offered for paying clients, and the public health care sector clients cannot, for the most part, pay for their services. As a result, without institutional support, the Coletivo finds it difficult to keep a paid staff to keep its services and projects running and to apply for new grants to support projects. In addition, it does not have enough staff to concentrate its efforts on raising funds, and it cannot hire more staff unless it receives more funding for projects. Its clinics and services provides 30% of its resources, but it still needs a regular source of financing to be able to provide the services at low cost and to develop new projects on women's health(future initiatives that could bring in funds), while keeping its staff employed.
As we are going to discuss in the following chapter, the importance of the Coletivo's contribution should not be measured by its client numbers but rather by its approach to women's health care: the special attention it always gives to sexuality within its regular services; its reputation in the community; and the voice its has, and continues to give, to a philosophy of addressing women's sexuality as fundamental to their well-being and to their SRH.

Chapter 4. Counselling – clients, content and continuity

4.1 A Helpline: Disque Saúde ('Dial Health')

4.1.1 Clients

In the approximately six years since it was founded in 2000, the Coletivo's Disque Saúde hotline has attended to 2,563 persons – most of them women (2,348) and some men (215). Originally designed to attend to women exclusively, spontaneous demand from men made the Coletivo staff rethink its stance regarding its women-focused service. It still remains the Coletivo's only service that also serves men. While 13% of the callers are looking for information about the hotline or other services, or are calling to denounce abuse committed against a third party, the majority of callers need assistance to solve questions or problems regarding sexuality and health.

Table 1: Disque Saúde client profile: data from 2000 to 2006

Disque Saúde	Women N= 2348	Men N=215	Total N=2563
Number of clients who received phone assistance	2059 (88%)	177 (82%)	2236 (87%)
Return calls from the same clients (in reference to the same problem)	757	73	830
Number of clients seeking information: - Address - To denounce abuse against a third party - Questions about the service	289 (12%)	38 (18%)	327 (13%)

Source: Coletivo database

The majority of the callers are adults aged between 25 and 49 years, followed by adolescents. It should be noted that information is missing for over a third of callers. Most have had some high school education or completed high school, and a significant number of them have some college education (over 10% – high by Brazilian standards). Information about educational level is missing for 46% of callers. Most are married (39%) or have been married (8%). The majority are employed and live in São Paulo City.

These results indicate that the assumption that a hotline would be more attractive to or serve more single and young people does not hold true for Disque Saúde. Rather, people with more experience and relatively high levels of education called the hotline for basic information on

sexuality and sexual health. On the other hand, these demographics may also show that the Coletivo has not been successful in reaching and attracting callers among the younger, less educated and poorer sectors of the population – the more socially vulnerable that may need the services the most.

Table 2: Clients' socio-economic and demographic characteristics

Age Group	Women N= 2327	Men N=215	Total N= 2542
10–14	0.5	0.0	0.5
15–19	10.0	7.0	10.0
20–24	14.0	9.0	14.0
25–49	37.0	28.0	36.0
50+	5.0	4.0	5.0
No information	34.0	52.0	36.0
Schooling level	Women N=2327	Men N=215	Total N=2542
College degree or more	7.0	4.5	7.0
Some college	3.0	5.5	3.5
High school	15.0	16.5	15.0
Some high school	17.0	5.5	16.0
Middle school (eight years of education)	3.0	0.5	2.5
Less than eight years of education	11.0	4.0	10.0
Illiterate	0.5	0.0	0.3
No information	44.0	62.0	46.0
Marital status	Women N=2327	Men N=215	Total N=2542
Single	26.0	30.0	26.0
Married	40.0	30.0	39.0
Separated	2.0	1.0	2.0
Divorced	2.0	0.0	2.0
Widow	2.0	0.0	2.0
No information	44.0	39.0	29.0
Employed	Women N=2327	Men N=215	Total N=2542
Yes	50.0	56.0	51.0
No	24.0	9.0	22.5
No information	26.0	35.0	26.5
Area of residence	Women N= 2327	Men N=215	Total N=2542
São Paulo City	62.0	47.0	61.0
São Paulo State	10.0	5.0	9.0
Other states	3.0	5.0	3.0
No information	25.0	43.0	27.0

Source: Coletivo database

4.1.2 Content

Information about the nature of callers' questions or problems is available for the vast majority: only 2% were missing. The most common questions presented by women related to contraceptives (how to use emergency contraception), followed by violence, and then sexuality. For men the main reason for calling was sexuality, followed by contraception and violence. According to the Disque Saúde attendant, when asked about the types of sexuality-related questions women asked, she stated that women tended to present questions about lack of pleasure or inability to have orgasms, while men had questions about impotence, penis size and how to give women pleasure or help their partner reach an orgasm. The callers also, but less frequently, asked questions about homosexuality, transvestitism and transexuality. Most questions were resolved immediately, but sometimes, if the attendant did not know how to answer, she would ask them to call again later or to leave a number where they could be reached if they wanted to (this happens in about a quarter of cases), and she would research the issue and get back to them.

Most callers ring the service only once with a specific question. They may call again but with a different question. They are not encouraged to establish a relationship with the attendant. She does not see her role as providing long-term counselling. It is an information and referral service. People with more complex problems are encouraged to seek therapy and other kinds of service. Referrals to services are made frequently, especially for women who were seeking abortions or who were victims of domestic or sexual violence. The Coletivo itself is one their main referral points for women seeking illegal abortions and for victims of domestic and sexual violence. The attendant refers women to the Coletivo, but the staff do not inform the client that the hotline is also a part of the Coletivo, to protect women's privacy and service anonymity. This makes it difficult to track how many women the hotline referred to the Coletivo. Unless the woman mentions it spontaneously, the Coletivo does not know if she was referred by Disque Saúde.

Most clients learn about the service from others who have used the service previously. About a third learn about the service through posters/flyers. The Coletivo has a separate phone line, and the hotline attendant works in a room alone. During the calls, only first names are asked for or used, and clients' privacy is always assured. When the attendant is away for lunch or a break or it is outside business hours, callers can leave a message or return the call. All messages are returned.

For the attendant, the secret to gaining the confidence of callers and making them comfortable to speak about intimate problems is her receptivity and the non-judgmental way she receives the questions. She sees it as a fundamental part of the Coletivo's approach:

> Here all of us have it (counselling skills), because to enter the Coletivo you have to have this (capacity). So, even the secretary who has nothing to do with the hotline, if she did answer a call, she would have the same receptivity, because it is the conduct of people here in the Co-

letivo to receive and not to judge and to answer the person's needs. Then, if a woman suffered some violence, sexual violence, for instance, she does not want you to ask anything about if she went to the police; this is something all of us here know. If a person calls and is a victim of violence, the first thing you have to ask is if she needs help; if she wants to come here; if she has medical help – help from someone who is going to be receptive to her, not from the police. We cannot mention this right away. If you ask that (mention the police), she will hang up immediately. She has to be warmly received, to stay put, quiet. This we all know. These principles are for us *'acolhimento'* ('receptiveness'); whoever she may be – a prostitute or a victim of sexual or domestic violence.

Table 3: Characteristics of service utilization by clients

How client learned about the hotline	Woman N=2327	Men N=215	Total N=2542
Posters	32.0	5.0	31.0
Indication	50.0	55.0	51.0
Internet	3.0	6.0	3.0
Newspaper	2.0	1.0	2.0
Magazine	7.0	5.0	7.0
Radio	4.0	5.0	4.0
Television	2.0	1.0	2.0
No information	2.0	1.0	2.0
Type of problem presented by the client	Woman N=2294	Men N=212	Total N=2542
Conception/infertility	2.0	0.5	2.0
Contraception	18.0	14.0	17.0
Pregnancy	4.0	5.0	4.0
Health examinations	7.0	4.0	7.0
Menopause	3.0	0.0	3.0
Sexuality	10.0	24.0	11.0
Violence	17.0	13.0	16.0
Drug use	1.0	1.0	11.5
Judicial assistance	6.0	4.0	6.0
Illnesses	12.0	10.0	11.5
Psychosocial	6.0	7.5	6.0
Others	15.0	18.0	15.0
Problem status	Woman N=2258	Men N=211	Total N=2469
Totally solved	85.0	86.0	85.0
Partially solved	15.0	13.0	14.0
Pending (waiting for a vacancy)	4.0	0.0	4.0
No solution	1.0	0.5	1.0
No information	3.0	0.5	2.0

Source: Coletivo database

4.1.3 Service continuity

The Disque Saúde hotline has been in existence since 2000 when it received support from the MacArthur Foundation in the USA. MacArthur financed the first four years of the service and the training of the attendants who worked there. In the beginning there was more money to publicize the service, and, as a result, there were many more callers. From a very active service with two attendants and several callers a day, the calls have dwindled to about two to four a day. In the last three years the hotline has functioned without any external support and is being self-financed by the Coletivo, so it has not had the resources to publicize its existence.

Initially there were two attendants answering the phone, but one was let go after some time after her performance was evaluated as poor by Coletivo staff. The hotline is still run by the same person who has been with the service since its inception. She has some training as a psychologist but without a formal degree. After being selected, she was trained by two psychologists from the Coletivo staff. She was also supported to do internships in similar services and took several courses on adolescence and sexuality, on contraception (including emergency contraception) and eventually a one-year course in attending to victims of violence, offered by the University of São Paulo. She also had very extensive training before starting work at Disque Saúde, and in the first year the attendants had a bi-weekly evaluation meeting with Coletivo psychologists. The attendant, that was let go was considered to be "too impatient to listen" to callers on the hotline.

The current original counsellor has thus been with the Coletivo since she began working with the hotline. After some years she started to participate in other projects at the Coletivo and is now coordinating a programme promoting HIV/AIDS prevention among sex workers which is financed by the Brazilian Government. She spends time between the hotline and other projects and has trained one of the Coletivo's clerks to help with the hotline whenever she is out working on other projects or having a break.

The main attendant has an extensive collection of reference material that can be used to help answer questions and make referrals. Although the Coletivo does not have an official protocol, one of the main sources of information on sexuality is its *Get Friendly with Her* booklet. Disque Saúde counsellors are provided with the booklet and other materials during their training. In addition, in recent years, staff monthly meetings have provided individual support and time for sharing information among the staff counsellors. Staff reported that they also feel comfortable calling each other to discuss more troublesome and complex cases. The main attendant acknowledged that the younger attendant she trained did not have the ideal profile to be in this position, as she was perhaps too young and did not have sufficient life experience (in her opinion) but was nevertheless an empathetic listener and referred all the more difficult

callers to her. Today, the one counsellor is responsible for answering the hotline phone calls, as she has done since the service began.

4.2 Counselling within SRH consultations (pre- and post-abortion; psychological and gynaecological consultations and pre-natal care)

4.2.1 Clients' characteristics

Data from the life history forms of 360 clients of the Coletivo SRH services were collected and entered into a database, maintaining client privacy and confidentially. No names or any other form of identification were used. They were randomly selected among almost 1000 clients who attended the Coletivo in the last three years. We calculated the sample size using the equation for a probabilistic random sample with a significance level of 5% for the total population. The data collected have various inadequacies, as they are derived from a self-administered questionnaire with only partial information. The information available refers to the clients' life histories at their first consultation – only some of which have been updated. Despite the limitations, the information collected allows us to present an overview of the Coletivo's clientele, their social and economic characteristics, and their sexual and reproductive histories and practices.

In our sample, most women were between 20 and 29 years old when they first visited the Coletivo. The majority declared themselves as white, which is comparable to the São Paulo population as a whole. Most (57%) were single at the time. Over 40% of them had a college degree or some college education. Around 40% worked in the service sector (in activities that demanded a low level of specialization) and had on average a monthly personal income of $600 or less. In general, the Coletivo's clients, when they first arrived at the service, tended to be young, middle-class women with a higher level of education. These characteristics are to be expected of a clientele who seek a more 'alternative' kind of health service. In addition, there is a smaller group of women from lower socio-economic strata, especially those involved in social movements and groups that have also, historically, sought the Coletivo's services.

Table 4: Clients' socio-economic and demographic characteristics

Age group	Frequency N= 342	Percentage 100%
10–19	44	12.3
20–24	89	24.9
25–29	77	21.6
30–34	58	16.2
35–39	49	13.7
40+	25	7.0
Colour/race	Frequency N= 303	Percentage 100%
White	200	56.0
Mixed (brown/black/white)	47	13.2
Black	30	8.4
Asian	16	4.5
Indigenous	10	2.8
Schooling level	Frequency N= 319	Percentage 100%
Primary school incomplete	39	11.0
Primary school	22	6.2
Secondary school incomplete	27	7.6
Secondary school degree	79	22.1
Some college	49	13.7
College degree	80	22.4
Masters/PhD	23	6.4
Marital status	Frequency N= 345	Percentage 100%
Single	200	56.0
Married	70	19.6
Living together	45	12.6
Separated	22	6.2
Divorced	5	1.4
Widowed	3	.8
Has children	Frequency N= 190	Percentage 100%
Yes	115	60.5
No	21	39.5
Employed	Frequency N= 313	Percentage 100%
Yes	251	70.5
No	62	17.5
Personal income (per month)	Frequency N= 226	Percentage %
Up to $300	91	25.5
From $300 to $600	61	17.0
From $600 to $1200	60	17.0
$1200 or more	14	3.5

Source: Coletivo Archives

Among the Coletivo's clients, 84% are sexually active, of which 93% had only heterosexual sex, 4.2% had sex with both men and women and 1.7% only with women. Among those who have had sex, 187 (52%) stated they had been pregnant at least once, and 115 (46%) have children (one child on average).

The majority (78%) had sexual relations in the last year, and most of them reported to have had one to three sexual relations per week. A very small number (3%) has the habit of using lubricants, and 7% douche after sex. Among the respondents, 12% had several different partners at the same time (within the last two years), and 10.7% have had over ten sexual partners. Some of the respondents declared they were sex workers (the Coletivo developed an intervention project for sex workers in the area, discussing prevention and offering consultations, diaphragms and condoms). For 24% of the women who were reviewed, their sexual life was not going well at the time. The most common reason given was lack of pleasure or interest in sex. Two-thirds of women (66%) said that they discuss sexual matters with their partners.

In relation to their sexual health, 74% had had a gynaecological consultation before, and a similar number (70%) had had a Pap smear. A lower number (43%) reported having had a breast exam, and a much lower number reported performing breast self-exams. In our sample, 20% of clients declared they had already contracted at least one STI. The most common STI reported was HPV. Most women (59%) stated they felt protected against HIV, and the same amount declared they were taking precautions against HIV/STI infections (the most commonly precaution was using condoms). Most clients (52%) declared they were using contraceptives at the time, 80 (51%) of whom were using condoms and 45 (24%) were using condoms plus another method. Among them, 59% said they were satisfied with their current contraceptive, and 65% had used other methods before (27% the pill).

When asked about whether they had ever been a victim of abuse or any sort of physical or psychological violence from a partner, 31% of them declared they either had suffered some form of abuse or were still in an abusive relationship (6%). In our sample, 54 women declared they were forced to have sex at some point of their lives. Among those who were ever a victim of some sort of violence, 56% sought help or at least told someone else. When asked about institutional violence, 50 (or 14% of them) stated they had felt mistreated in a health service, a police station or in some other type of service.

4.2.2 Content

Service procedures and environment

At the Coletivo, service is provided through individual gynaecological services where discussion of sexuality is an integral part of care. Fundamental to the Coletivo's counselling philosophy and to its success in integrating sexuality into its services are its service delivery environment and procedures that are designed to make women feel comfortable, safe, and open to discuss intimate issues with skilled lay and medical providers. This approach is part of the Coletivo's holistic humanizing credo to engage and treat women respectfully and to promote their sexual and reproduc-

tive health and rights through their services. This approach is evidenced in the service procedures any client goes through when he or she seeks services at the Coletivo.

A typical gynaecological care session features the following steps and interventions from the moment a woman enters the clinic until she leaves – many of which actively include a discussion about her sexual well-being, concerns and problems.

The client enters the reception area, where a trained receptionist confirms her appointment and gives first-time clients a sexual health life history form – called an *anamnesis* – to complete. The form is lengthy and includes several pages of detailed questions about the client's health and nutritional status and her sexual and reproductive history. In the form she is asked very directly if her sexual life is satisfactory, if she has any problems or concerns, and what kinds of preventive practices (safer sex and contraceptive use) she may be using.

After filling in the form (if she cannot write, the secretary assists) she waits in a common area where other women may also be waiting for different services such as abortion counselling or pre-natal care. As a member of the staff observed: "At a given time you can find a nun, a prostitute and a lesbian in the same room, waiting for their consultations." When the client's turn arrives, the professional goes downstairs (the consultation rooms are upstairs), introduces herself and hugs the client.

In the consultation room they sit down, and the professional reviews and discusses all the information in the form, providing a great deal of time and space for clients to present their own questions and worries. The questions on sexuality in the form provide an opportunity for the professional to ask about the client's sexual life and for the client to discuss it if she so chooses. The detailed review of the life history is an integral part of the consultation and sets the stage for further discussions and questions about what clients may feel are very private and personal issues. The intimacy established between the client and provider makes discussion about sexual problems or concerns possible.

After the initial discussion about the sexual life history, the professional explains that "they" will need to do a vaginal examination. She explains what kind of examination should be done and invites the woman to perform a self-examination. If she agrees, she is then asked to lie down on a sofa (not a gynaecological bed) and is shown how to do a self-examination of her vagina and cervix. She is shown how to introduce a plastic speculum inside herself, and, with the help of a mirror and a flashlight, the professional shows her the cervix and discuss its appearance and colour (and what that means). The professional then collects a vaginal swab for a Pap smear and also for an 'al fresco' exam to check for any 'irregularities'. The Pap smear is sent to an outside lab. A breast examination is also performed, and the professional checks the client's blood pressure and abdomen. After the examination they discuss the results, and the client receives referrals or prescriptions if

needed. The Coletivo relies as much as possible on alternative medicines, and the professional and the client discuss nutrition and the use of medicinal plants and foods to help with healing.

The professionals observed at the Coletivo gave a very warm welcome to their clients and showed empathy and understanding during consultations. They created an intimate atmosphere which helped clients open up and share sexuality-related concerns and problems. Many clients found the self-examination and discussion liberating and shared that it was the first time that they had ever dared to touch or look at themselves and that the information they received changed the way they saw themselves and their sexuality.

Client reports following counselling services

Twenty-three post-consultation interviews were held with clients as they exited their consultations. The clients interviewed were young, most in their 20s (median age 29.5 years), the majority were married, living with their partners and children at the time, and most declared themselves to be Catholic or non-religious. Thirteen of them were there for a gynaecological consultation, eight for pre-natal care, one for psychological counselling, and one for pre-abortion counselling. For eight of the clients, this was their first time at the Coletivo. The large majority of them (18) learned about the Coletivo from a friend or a family member. Most of them were there for routine gynaecological or pre-natal care, and half of them were there because they had used the service before. Accordingly, the most common kind of information received was gynaecological or obstetric. Although only six of them said they received information on sexuality, the fact that most of them were long-term clients may mean that this subject has been discussed in previous consultations. As the life history form is completed in every first consultation, when they were asked questions regarding their sexuality and sexual experiences, in this particular consultation the issue did not come up as a subject.

Table 5: Services received by the Coletivo's clients from January through June 2007

Kind of service received	Frequency N= 23	Percentage 100%
Gynaecological consultation	13	56.6
Pre-natal care	8	34.8
Abortion counselling	1	4.3
Psychological counselling	1	4.3
First time at service?	Frequency N= 23	Percentage 100%
Yes	13	56.6
No	8	34.8
No information	2	8.6
How client first learned about service	Frequency N= 23	Percentage 100%
Referral from a friend	14	61.0
Referral from a family member	4	17.5
Referral from other health care facility/professional	1	4.3
Psychological counselling	2	8.7
GAMA (pregnancy support group located in the same building)	1	4.3
Referral from another client	1	4.3
Reason for consultation	Frequency N= 23	Percentage 100%
Gynaecological consultation/routine	12	52.2
Pre-natal care	8	34.8
Information on contraception	1	4.3
Information on or treatment of STIs	1	4.3
Abortion counselling	1	4.3
Psychological counselling	1	4.3
Other	1	4.3
Why chose this specific service?	Frequency N= 23	Percentage 100%
Has been here before/old client	11	47.8
Only place with the type of service they needed	6	26.1
Referral from a friend	4	17.4
Referral from GAMA	1	4.3
Referral from a family member	1	4.3
Kind of information received during consultation	Frequency N= 23	Percentage 100%
Gynaecological	17	73.9
Pre-natal care	8	34.8
Sexual pleasure/sexuality	5	26.1
Domestic/sexual violence	0	0
Unplanned pregnancy	8	34.8
Fertility	6	26.1
Nutrition/alimentation	8	34.8
HIV counselling	2	8.7
STI counselling	5	21.7
Family planning counselling	4	17.4
Emergency contraception	1	4.3
Other	4	17.4

Source: Exit interviews

Regarding clients' perceptions of the service, they reported very high levels of satisfaction. With only one exception, all clients interviewed said they were received and professionally attended in a friendly, respectful and non-judgmental way. They felt they were stimulated to talk and listened to. On professional behaviour during the consultation, everyone declared the professional spoke clearly and professionally, used a gentle and soft tone, gave them time to absorb the information, allowed them to ask in more detail about the information given, and answered their questions satisfactorily, repeating or reinforcing important information while giving them time to think about possible questions. Several clients also stated that the professional corrected false information and at the end resumed the main points discussed during the consultation.

Consultation content

All clients declared they were able to discuss their questions and to share their worries and concerns. In the last consultation ten clients interviewed (44%) discussed sexuality-related matters, of which four (17%) had their knowledge about HIV and its means of transmission verified and were asked about their exposure to HIV. Five (22%) received information on HIV and how to have safer sexual relations. Nine (39%) discussed pregnancy prevention, and one discussed questions related to sexual/domestic violence. Seventeen of the clients interviewed (or 74%) received a referral to another professional or were asked to return. One client thought she needed to be referred and was not. Thirteen clients were told where to get the service they were referred to. Nineteen were told when to come back to this service. Most of the referrals were for laboratorial/ultra-sound exams.

Service environment

All clients interviewed considered they were attended in a private place and felt comfortable with the professional attending them. Twelve of the 13 clients who had been there before were attended to by the same professional as before. Only one declared that she would have liked to be attended to by another professional (she wanted to be seen by a doctor and by someone younger).

When asked what they liked most about the service, most of them cited "time allowed for consultation" and "feeling free to discuss worries and concerns", followed by "attentive" and "receptive professional". The information received and the fact that it is a feminist/humanized service followed for 40% of the clients as what they liked best about the Coletivo. When asked about what they liked less, two mentioned time allotted to consultation, one waiting time, and another one the information given. However, all 23 would recommend the service to others. When asked about what kind of services they would like to see (that are not currently offered), four mentioned more professionals with different specialisms, three to have educational activities/workshops, two services for youth, and four to have more integrated activities.

Table 6: Exit interview respondents' socio-economic and demographic characteristics

Age group	Frequency N= 23	Percentage 100%
15–24	8	34.8
25–34	10	43.5
35+	4	17.4
No information	1	4.3
Religion	Frequency N= 23	Percentage 100%
Catholic	6	26.1
Pentecostal	3	13.0
No religion	7	30.4
Christian	4	17.4
Other	2	8.7
Marital status	Frequency N= 23	Percentage 100%
Single	6	26.1
Married	15	65.2
Separated/divorced	1	4.3
No information	1	4.3
Living situation	Frequency N= 23	Percentage 100%
With parents	5	21.7
With a partner	9	39.1
With a partner plus children	4	17.4
Alone	1	4.3
Alone plus children	1	4.3
With other relative	1	4.3
With parents plus partner	1	4.3
No information	1	4.3

Source: Exit interviews

Chapter 5. Sexuality counselling at the Coletivo – successes and challenges

In this review the **quality of the counselling intervention** has been investigated using the following indicators as a measure:

- provision of quality counselling services that ensure privacy;
- guaranteeing confidentiality of records and clients' details;
- helping clients to identify and explore options for addressing their needs, problems and desires related to their sexual life;
- providing information, treatment and referral for diagnosis, treatment and care of sexual health-related illness;
- following service delivery guidelines, standards and protocols that all staff have been trained in within the past two years;
- offering counselling and services for partners and families of clients;
- ensuring client–provider communication/interaction that is respectful, non-judgmental and friendly; and
- for returning clients, ensuring that updated records are kept, maintained and used in return visits.

The **efficacy and sustainability of the health service delivery setting** where the sexuality counselling was taking place was assessed qualitatively by looking broadly at facility and service conditions. Information was gathered from a variety of sources (see Chapter 2 for methods used) to assess:

- the organization of services;
- human resource development issues such as criteria for selection of providers, salaries, workloads, supervision, training and systems;
- infrastructure and logistics, including adequacy and use of space, condition of the facility, patient flows, layout, equipment and supplies;
- monitoring and evaluation of service quality;
- responsiveness of services to clients' needs, including accessibility and acceptability of services;
- links to referral networks; and
- funding, leadership and reputation.

Finally, these measures mentioned above facilitated a qualitative assessment as to **whether the specific sexuality counselling intervention contributed to the overall success of the programme** or clinic's services.

In this chapter we summarize the findings from the assessment in these three broad assessment categories.

5.1 The Coletivo's success

The success of the Coletivo's sexuality counselling model is evident at the individual client level and at the community level. While 'success' in such a review is difficult to quantify, many of the quality components listed above were assessed positively. Challenges were found in the service delivery structure which raised questions about the overall sustainability of the service base. Finally, when we attempted to assess the contribution of the counselling intervention to the overall success of the programme, we found that the very attributes which made this model of sexuality counselling and SRH service delivery so unique may also be a limitation and constraint to the organization's growth and sustainability over time. The impact of the service at the individual level is evident in the way clients describe the service experience. As one client stated:

> …but the physical part: I was completely ecstatic about it. I think I talked about it for a whole month. I had already had routine gynaecological exams, and they are so different. I had done it with men and with women, and it is always like that in a common exam: your body is there, but you are not there. And here I am always present. For me this is the most important thing; it is good. So I felt that the physical part was the coolest of everything: 'Look, this is you inside.' The first time I saw myself inside I was ovulating, and I said: 'Oh, my, how beautiful I am!'
>
> (Joyce, 41 years old)

5.1.1 Quality of the counselling intervention

The services begun at the Coletivo by a group of committed women's health activist were feminist in perspective and political in orientation. The orientation was holistic, woman-centred and rights-based before such terms and modes of delivering services became the fashion in Brazil and elsewhere. A full ten years before the International Conference on Population and Development, the Coletivo aimed to provide rights-based services for women, using participatory methods that focused on self-knowledge, a safe space for dialogue and questioning, and non-stigmatizing language about sexual orientation, preferences and body image.

> We were a lot of brothers and sisters, and in my house we never discussed it (sex)... everything was hidden, in silence. After I came to the Coletivo I started

> to have my own knowledge. I remember quite well the first time I was here with Simone, and it was wonderful, I left here flying.
>
> (Mary, 56 years old)

From the moment clients entered the clinic – either through the hotline or in person – privacy of personal information, confidentiality of records and clients' details were assured. Life history forms were filled out by women (with assistance if needed) in detail and used to guide the discussion in the counselling room. As all services share a common waiting room on the first floor (separate from the consultation rooms upstairs) and clients are addressed individually by providers, anonymity and secrecy about the purpose of the visit was assured. Testimony to the success of this approach is a counsellor's recognition of the diversity of clients – from Church workers to sex workers and lesbians – in the waiting room who cannot be distinguished from one another, each feeling equally respected.

> I like it here because we arrive and are received right away. She already comes with that big smile. When you go to a doctor you already sit tight, trembling with fear because they won't care about your pain, they won't treat you with respect, and they will barely talk to you. Here you get to know yourself, you don't feel pain, you see you are caring about your own health, in a very natural way.
>
> (Virginia, 27 years old)

Fundamental to the Coletivo's approach is the life history recording the client's sexual life. This detailed form creates the basis from which discussions of the client's sexual life, sexual health concerns and sexuality-related issues are addressed. It also facilitates a provider–client relationship that is safe, intimate and open. Through discussion of the form, clients are given time and space to explore sexuality-related issues.

> She has a way, a technique of talking to you that makes you let loose, and she can breach this area of sexuality, of pleasure.
>
> (Thelma, 42 years old)

> My sister told me their services were special. You didn't use those things to put your feet up... and you looked inside yourself and were very well attended. I got curious about that and came for a routine exam.
>
> (Joyce, 41 years old)

Partner issues are raised, and couples counselling is offered if desired. The provider is respectful, non-judgmental and friendly.

> In the first consultation with the doctor, I was living with a woman, and I felt comfortable to tell her. You got to open up about that because there are problems of heterosexuals and of homosexuals. Everyone here, the doctor or 'Ju' (the health aid) treats me well and gives me every kind of information.
>
> (Claire, 49 years old)

The communication shared between provider and client creates the safety for the provider to lead the client to do a self-examination of her own vagina and cervix. Clients overwhelmingly report the value this experience had for them.

> I found it so interesting; I liked it very much. This was one of those things my mother and I talked about this consultation. Of it not being such an invasive thing. It is always such an embarrassing moment during a consultation, and we found it (the self-exam) so interesting; we liked it so much.
>
> (Carolyn, 32 years old)

> I found it so cool, because in the other centres you don't get to know yourself. And when you start to see yourself inside... that mirror, I found it wonderful! Because suddenly you have control over you own body; it is a region that we have a barrier against from a very young age, isn't it?
>
> (Patricia, 46 years old)

The self-exam is supervised and facilitated by the provider who also takes a vaginal swab to perform necessary lab tests according to standard gynaecological treatment protocols. Results are explained to the women in clear, holistic language, and treatment is recommended following the principal that less intervention is more. Natural homeopathic remedies are suggested when possible. Women leave their sessions content and satisfied, and some report a personal transformation.

Below are some of the reports from clients:

> I felt I could talk about anything to her. My first relationship where I lived together with someone was with a woman, and I asked her: "Look, in my head this is a kind of a resolved matter, but do I need to have a label or something about it?" And she said "no"; she even said: "Look, for me this just looks like you will have more chances, because you don't have only 50%, when you look at the world you have 100%; you are not stuck with men, are you?" That was so nice, gave me such a comfort. I had already resolved that, but you are always fearful to be labelled. That's so cool, and I would never ask any other (provider).
>
> (Joyce 41 years old)

> The Coletivo helped in my case, with my husband, because there are women who think penetration is everything. I learned here, and I also gave tips to my husband. We don't use penetration as much now; we use more touch, tongue. And I feel better with that than with penetration.
>
> (Joanna, 40 years old)

> I was 25 years old when I started my sexual life. A little bit late. It was very different to sit in that chair/bed and put the speculum in myself and to know it was not going to hurt. She placed the mirror and showed the whole cervix. We talked a lot. After that I also did the breast self-exam. For me it was wonderful. It was when I started to awaken to my own sexuality, how it works. I made sure to pass it on to my niece since she was a kid.
>
> (Patricia, 46 years old)

> We had a conversation in the middle of the consultations (about sexuality) but nothing specific. The self-exam made me want to read, look for, research, seek information on my sexuality.
>
> (Silvia, 35 years old)

> I had a problem and said to Ju: "Ah, I am 'frigid', and I don't know what it is." And she told me to check the touches, because "if you miss it, it is not your problem, it is the guy's. Talk to him, tell him, explain him what you need." Then she taught me a few things that worked.
>
> (Judith, 42 years old)

5.1.2 Efficacy and sustainability of the health service delivery setting

The Coletivo is a collective with a horizontal management structure. All members of staff are involved in the collective and have a say in decision-making. Lay providers work side by side with a trained doctor and a psychologist. The receptionist fills in on the hotline when needed. Supervision and training are done collectively through regular staff meetings and in service support. Staff are hired based on their knowledge and, importantly, on their commitment to the Coletivo's model of women-centred, holistic, humanistic service delivery. Problems are discussed by the staff in these regular meetings, and solutions are found.

This model has been in place at the Coletivo since its inception. In the early years when there was a larger, more highly skilled staff, and a larger client and funder base, the services ran smoothly. Materials and 'protocols' were developed based on the latest evidence which was overseen by trained obstetrician/gynaecologists on the staff. Documentation such as *Get friendly with her*, a visually explicit guide to women's health and bodies, was used as a protocol for services such as

the self-exam, with its contents reviewed by trained physicians. In fact, this document has been used by many women's health organizations in Brazil as a novel and important resource to help women get to know their bodies, similar to the later American version of the same, *Our Bodies Our Selves*, from the Women's Health Book Collective.
The Coletivo's facility, since it moved into its own house in 1994, is a warm, centrally located site that offers the space and layout needed for the services offered. Equipped with a waiting room, a library which doubles as a meeting room, and a clinic space, the facility serves the Coletivo's size and needs well.

Client feedback is monitored, as this assessment shows, and records are well kept and reviewed regularly to ensure service improvements. Client satisfaction is highly valued, as this client-centred service centre advocates. Referral networks are maintained, and training for staff and other organizations is done on request. Requests in recent years have come from government hospitals, the Catholic Church, police associations, and lesbian associations, to name a few. All sought training on how to speak about and better address their constituents' sexual health and sexuality-related issues such as violence against women. Requests such as these demonstrate the Coletivo's leadership and reputation in the community.

Further evidence of the Coletivo's success at the community level is in the dissemination of its individual and collective expertise such as:

- The Coletivo's founding members were early leaders in the national, regional and international women's health movement (even before the International Conference on Population and Development). The Coletivo was one of the founding institutions of the Brazilian feminist network for sexual and reproductive health.
- Several of the founding members went on to found other women's health organizations around the country, as well as to research institutions, universities and public office. As a result, the Coletivo's philosophy on humanization of women's health care has had a deep impact on the Brazilian public health care system.
- More recently, sex workers served and trained by the Coletivo have gone on to open their own organization to fight for sex workers' health and rights with the support of the Coletivo staff.
- The Coletivo continues to receive innumerable requests to provide community-based training on women's health and sexuality from a broad spectrum of service organizations. This demonstrates recognition of its staff as experts in the field.

Despite the enduring commitment of staff, client loyalty and early funding support, the Coletivo today is facing major challenges. At the time of this assessment, staff numbers have reduced to less than six regular staff members, which in turn has dramatically reduced the services that can be offered. Decline in client load has occurred because clients must pay out of pocket for the Coletivo's services. The Brazilian universal health insurance scheme does not reimburse services

provided by the Coletivo, and nor does private insurance for the most part. As a result, women must pay out of pocket for the services they receive, which has become a debilitating barrier to the provision of what is now a specialist service. This is tragic, given the Coletivo's spirit of providing non-discriminatory, respectful services to women who may feel considerable barriers to conventional services, such as lesbians, sex workers, victims of violence, and others who may not feel comfortable with the traditional service model.

Organizations such as the Coletivo must either charge high fees to be self-sustaining or they must write grant applications and conduct research and training initiatives in the community to subsidize their services for their client base. Both approaches are problematic for the Coletivo. If the Coletivo charges high fees, it will be forced to change its client base and appeal to a high-income clientele. Given its philosophy of collectivism, solidarity, lay health personnel, and flat structure, all aspects of a collective which are not familiar to a broad, mainstream client base, a new appeal to expand its services in this direction would be difficult indeed. For the Coletivo to raise alternative sources of funding, which is likely to be its best hope, requires new and innovative delivery of its services to wider audiences. The Coletivo has the experience and reputation to strengthen its financial base by going in this direction. The challenge lies, however, in the grant application writing, and presentation of the Coletivo. Many of the highly skilled leaders of the Coletivo have either moved on or have competing interests and time constraints. The horizontal structure has not developed new leaders to fill the management vacuum that has appeared in recent years, and old donors expect no less than self-sufficiency. In the coming years, the Coletivo must develop new partners and create new initiatives if it is to continue to play the role it once did in the women's health movement as a service provider, and achieve financial stability and self-sufficiency.

5.1.3 Has the specific sexuality counselling intervention contributed to the overall success of the programme?

The Coletivo provides counselling as an integral part of all of it SRH services. In all counselling sessions, discussion of sexuality and sexual health problems or concerns are systematically raised as part and parcel of the prevention, treatment and care protocol for SRH interventions such as pre-natal care or abortion counselling. The appreciation and value clients give to the Coletivo's services were evident in this assessment and, perhaps most significantly, in their choice to pay directly for services and their willingness to come back and recommend the services to friends and family. Clients and staff make up a Coletivo family which embodies the spirit of the organization.

As in all families, however, the very aspects that keep it together may also limit its growth and expansion. The philosophical position of the organization to offer holistic, women-centred services through a horizontal service structure may be a limiting factor to the organization's

growth today. The structure, for example, may have contributed to limiting the development of new leaders, which in turn has resulted in a diminished financial base for the organization due to a shortage of new projects that new leaders could facilitate to bring in vital resources. New directions and initiatives may in turn further distract from the original focus of the organization, which would require accepting an organizational model that is more fluid and changing. Balancing these competing challenges is a hurdle most activist organizations must face. Recently, new projects such as the Coletivo's work with sex workers show promise, but follow-up initiatives are needed. In discussions with staff, however, there appears to be too few people to develop and lead new projects. For the Coletivo to move forward and stabilize its financial base, new thinking about its management structure – where everyone and at times no one is in charge – should be reviewed. The Coletivo, with such a strong heritage and commanding voice in the women's health movement, will endure this crisis – particularly if founding members and friends work collectively to restructure the organization to overcome the current challenges they now face.

5.2 Challenges for scaling up

In conclusion, challenges to scaling up the Coletivo's model can be summarized as follows:

- Small, intimate and committed staff is hard to replicate.
- Financial viability and sustainability remain problematic.
- Cultural and socio-economic barriers exist that limit the Coletivo's ability to expand the client base, given the institutional aim and objectives.
- Resistance of the medical establishment to the model of women's self-care and holistic medicine limits future access to insurance packages.

Questions that remain when reviewing a sexuality counselling and service model such as the Coletivo's are whether, even in a country like Brazil which has greater resources and openness than others, sexuality can be mainstreamed and medicalized? Does scaling up require such compromise?

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